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Editorial

The Addicted Doctor
Caring Professionals?

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The alcoholic colleague was described as 'neglected' by Edwards in 1975. The last 20 years has seen only patchy progress, even though we know that the prognosis is better than originally thought. Some countries, such as the United States, the United Kingdom and Spain, have established procedures for intervention and management, but in many countries these problems receive little attention apart from disciplinary measures. Even if therapeutic structures are in place, doctor addicts, partly for the reasons described in this paper, do not always avail themselves of them. The position of addicted doctors is still bleak.

This paper arose out of a retrospective casenote study of 144 doctors with substance misuse problems seen at a postgraduate teaching hospital from 1969 to 1988 (Brooke *et al*, 1991, 1993). The findings do not convey the full story; they omit the attitudes and environments which enabled substance misuse to occur. The problems of these doctors were neglected. Their support and supervisory structures failed them due to a combination of poor training, hesitant management and uncertainty. In the present paper we stand back from the data and use qualitative material to examine the issues arising in the following areas: professional attitudes, difficulties in assessment, patient care, the doctor's family, the role of colleagues, formal procedures and the role of the General Medical Council. The paper concludes with suggestions for prevention and intervention. Where case material is quoted, minor alterations have been made in the interests of confidentiality.

The subjects were between the ages of 24 and 69. They came from all specialities and all grades of seniority and they had been experiencing problems with drug and alcohol use for six years on average before presentation. Virtually all the drugs misused were pharmaceutical preparations, rather than black market supplies. There was evidence of vulnerability (for example, personality difficulties or emotional problems) in all age groups, although a quarter had drifted into substance misuse with no clear precipitants.

"Regularly drunk as a house officer . . . within social norms": professional attitudes

The quotation is from the notes made by a registrar admitting a doctor with alcoholism. The profession has an airy familiarity with mood-altering substances which fails to acknowledge the potential for their misuse by doctors. Reports from Venezuela and India suggest that over 10% of doctors in training posts are regularly taking hypnotics (Sethi & Manchanda, 1980; Baptista & Uzcategui, 1993). Several of our subjects were prescribing opiate analgesics for themselves. The reasons may have appeared plausible (for example, a young, single-handed general practitioner was prescribing himself pethidine for his migraines), but sometimes there was a shadow of heavy drinking raising suspicions in the background. Many of our subjects had not registered with a general practitioner. Even when registered, some doctor patients had resisted the proper course of action: one man with depression should have had expert help after a suicide attempt one year prior to his index contact, but he persuaded his GP not to admit him. All of these factors contribute to a lack of rigour in the health surveillance of doctors, despite their unique occupational stressors (Richards, 1989).

The relationship between perceived stress at work and substance misuse appears to be mediated by individual vulnerability (Vaillant *et al*, 1970; Firth-Cozens, 1992). Such vulnerabilities were frequent. One subject, described as 'rude to people', was anxious and perfectionistic and had won many prizes. Another case was a sensitive, introverted man with obsessional traits who worried greatly about what others thought of him. He was over-committed to his work and was professionally very successful. He found it difficult to seek help for a condition which attracts such opprobrium as substance misuse. Vulnerable personalities may find themselves to be professionally isolated, which was a further predisposition to substance misuse in some of our subjects. One man left the Army after 20 years and took a post in a small hospital. He missed the conviviality of mess life and his drinking escalated.

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Another subject, a single-handed GP, was managing a huge list in a rural area, totally subsumed to the needs of the practice; even his wife was the district nurse.

General practitioners were perceived by our subjects as 'hostile to alcoholics', and this impression is confirmed in the literature; both hospital doctors and general practitioners have unfavourable views of alcoholics and drug misusers (Glanz, 1986; Thom & Tellez, 1986; Brown-Peterside *et al*, 1991). Not only does the profession regard self-prescribing lightly, it is then judgemental towards those who develop problems. The origins of these attitudes lie partly in a training which devotes, on average, 14 hours in five years to substance misuse, including alcohol problems (Glass, 1989). Lack of training in the management of addiction problems leads to a sense of therapeutic impotence and irritation at the relapses that are part of the natural history of the condition.

"Denied his problem right to the bitter end": the difficulties of assessment

Assessment is complicated by denial, depression, personality difficulties and uncertainties about prognostic factors. Nihilistic views of addiction affect the afflicted doctor, as well as the profession. These views contribute to denial, which is part of addiction (Talbott, 1987). The degree of denial can be extraordinary: two subjects denied drinking, despite blood alcohol levels of 200–300 mg%. Denial is a multifactorial problem. The addict is determined not to jeopardise his (or her) job, thereby believing that the substance use is not serious "because I've still got my job". Other doctors are unwilling to diagnose addiction problems in a colleague, and these diagnoses are difficult to make. In the face of strenuous denials it can be almost impossible, even after a full psychiatric assessment, to be sure. One subject engaged in secret drinking, denied by himself and unsuspected by all, despite pancreatitis, a post-operative confusional state, depression and a deteriorating marriage.

Depression is a common finding. Determining whether it antedated the substance misuse, or is a consequence of the steady deterioration in the quality of life that follows dependency, is difficult. Similarly, determining the contribution made to a chaotic lifestyle by personality difficulties may not be possible without a period of evaluation while free from drugs and alcohol.

Our understanding of prognostic factors is poor. Although many subjects recovered fully, the subsequent history showed some to be recidivists. At first contact, it is often impossible to differentiate between those who will go on to recover brilliantly and those who will continue in addiction.

"Unconscious on duty": patient care

It was rare for a complaint from a patient to initiate help-seeking among our subjects; much more usually, patients apparently endured the organisational chaos that surrounds the untreated substance misuser. In general practice, patients may vote with their feet:

> "... lately, patients have commented on behaviour during a consultation – of being motionless and unreceptive. The average number of patients seen in a 2-hour session being four to six as patients are reluctant to consult this doctor ..."

One practice tolerated astonishing behaviour in the surgery without insisting on change:

> "... when she came to take evening surgery, she brought a bottle of drink with her in a plastic carrier bag, and often appeared to have already drunk a certain quantity. Empty bottles were hidden ... vodka in her locked drawer. Empty ampoules of morphine appeared in the used needles container ... on days off she would come in and fill her bag with needles and syringes. Patients occasionally brought in a package from the chemist for Dr X which I noticed contained morphine. Puffy hands ... general condition deteriorated ... forgot to lock the surgery door ..."

Even with the full resources of a teaching hospital, documented failings in patient care may not be acted upon immediately. During one doctor's drinking career, nursing staff had noted several incidences of behaviour that was "unpleasant; swearing in front of patients ... publicly reprimanding clerical staff ... relatives commented that this doctor was drunk and had a disappointing attitude".

"Everyone living in hope": families too rarely a force for change

For the majority of our subjects, substance misuse developed in the family setting, and spouses were the first witnesses to the problem. One man's wife had objected to his heavy drinking for ten years, but his colleagues were reported as noticing 'during the previous few weeks'. Too often, loneliness, sadness, anxiety, anger and guilt is the lot of the addict's spouse; intimately involved, but too enmeshed and frightened to seek solutions, they may wait apprehensively for many years before a drink-driving accident or a formal procedure heralds official recognition of the problem. They may attempt to protect the user from the consequences of

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intoxication, for example, answering telephone calls and 'covering up'. This is well-intentioned, but it is unlikely to change the situation.

There may be an element of collusion with the user. In some relationships, the partner will be misusing substances too (Williams *et al*, 1991). Spouses may be used as justification: at least two of our subjects claimed that they were obtaining controlled drugs for their wives' illnesses. Nonetheless, the partner can be a force for change. One man was refused references from his house jobs and dismissed from several posts because of being intoxicated on duty, but remained unconcerned until his fiancée insisted that he attend for treatment. (Note that his employers had taken no action, other than dismissal.) Al-Anon (for partners of alcoholics, a sister organisation to Alcoholics Anonymous) often suggests that partners cease to protect alcoholics from the consequences of their drinking.

"Others know about his drinking and it has come to my ears from more than one source": the role of colleagues

It was the usual experience of our subjects that general practice partners and hospital colleagues were unsure how to proceed, even in the face of irrefutable evidence of damaging substance misuse. This is a reflection of uncertainty within the profession and it is a topic that demands discussion and consensus. Responses to our subjects varied from the draconian to the *laissez-faire*. A GP trainee with a vulnerable personality and several recent sad life events started self-injecting on a long-standing background of excessive drinking. The trainer dealt with the matter by sending for the police. Some general practitioners, perhaps with brain damage or hepatic cirrhosis, were sacked from their partnerships after their plight had been ignored for years. It is possible for a partnership to be dissolved because of a doctor's drinking and for this doctor then to obtain locum jobs with no helping or constraining action being taken. It is remarkable that some subjects were still functioning professionally having progressed their alcoholism all the way to delirium tremens.

With regard to career review, there are few mechanisms for sharing information constructively about a doctor whose performance is unsatisfactory. One subject, an overseas graduate, was slurring his words on duty and importuning for ephedrine scripts, but no firm action was taken and there was no liaison between the hospitals where he worked. Unaware of these problems, the overseas committee of the GMC extended his registration. Once out of a career structure, opportunities abound in hospital practice for anonymous locum work and for unsupervised non-training posts. Examples among our subjects were a clinical assistant, drinking all the way to brain and liver damage, and a marginally employed foreigner who had been in the UK for ten years, doing an enormous number of locums. (There is no evidence that substance misuse problems are more common in overseas graduates, but, should dependency develop, their difficulties in an alien culture may appear magnified.)

Uncertainty about management may develop into frank conniving, whereby colleagues are lulled into a sense of false security and collude with the addicted doctor to deny the problem. The sick doctor, having exhausted other employment possibilities, is at risk of being exploited by such colleagues.

Formal procedures

There are NHS mechanisms to intervene for problems with hospital doctors (the special professional panel, known as the 'three wise men') and with general practitioners (the local medical committee may make recommendations to the Family Health Services Authority). Few of our subjects encountered these mechanisms, suggesting that their implementation is sporadic. This may reflect a combination of ignorance about the procedures, plus the perception that involving them will be damaging to the career of the sick doctor. The response of these agencies is not always optimal. One subject was drunk at work, the three wise men were involved and he was reinstated with a warning, but no long-term monitoring. He continued to drink. Another subject used locums to cover his general practice while he went on 'benders' of up to five weeks' duration, every three months or so. The Family Health Services Authority allowed him to go single-handed after being hospitalised for alcoholism, thus exposing him to the dangers of professional isolation and lack of supervision. These mechanisms are imperfect; they share the uncertainty of the profession in managing addiction problems. However, there are no such procedures at all for doctors in private practice.

"Presented self at clinic one month before first hearing": the GMC

The General Medical Council (GMC) established the health committee in 1980 (Smith, 1989). Usually, information about addicted doctors referred to the Council is reviewed first by the screener for health. If there is sufficient reliable evidence to bring a doctor's fitness to practice into question, he or she

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is invited to be medically examined. On the basis of these reports, the doctor may be asked to agree to medical supervision and, if necessary, to limitations upon practice. This is a confidential procedure which does not involve any restrictions upon the doctor's registration, but because it is administered by the profession's regulatory body, most doctors cooperate. Only a minority of sick doctors are referred to the health committee. If the subject achieves abstinence, a period of suspension may not be necessary. Nonetheless, despite the GMC's undoubtedly caring ethic, these doctors sometimes suffer from a professional structure that fails to accommodate individual needs when in recovery from addiction. There were examples of second penalties among our subjects. In the case of one doctor, the GMC said he was fit to work after a period of suspension, but that certain aspects of his work should be cut back. In view of this, the health authority terminated his contract. Second penalties occur in general practice, too; one general practitioner was oppressed by layers of procedures, including a service committee complaint and the threat of an NHS tribunal, despite his splendid recovery from addiction. Rehabilitation can be an intimidating prospect, particularly if the case was widely publicised. It is not surprising that some doctors choose to change speciality, but it is uncertain if the outcome is improved by this manoeuvre.

Prevention and early detection

There were a few subjects who were perhaps misplaced in medicine from the start. However, the vast majority of our subjects were people whose vulnerabilities became more apparent with the passage of time and the selection procedures for medical students cannot be expected to predict future personality development. There is a strong case for increased health surveillance at both undergraduate and postgraduate levels. Some subjects had spectacularly problematic undergraduate careers following on from illicit drug use during their teens. One man needed admission for detoxification prior to the final examinations, but no other action was taken. He was not offered specialist help and supervision until he developed alcohol dependency syndrome.

House officers emerge as a worrying group. They maintain the risk factors that they have already developed, and they incur sleep deprivation, overwork and disillusionment (Dowling & Barrett, 1991). Those already at risk, such as recreational drug misusers, find that many more substances are available, from 'professional samples' to the pharmacy contents at night (McAuliffe, 1984). One houseman became depressed and started using benzodiazepines intravenously. His career was saved because of sympathetic and constructive handling by the local 'three wise men'. An ENT house surgeon started using cocaine, apparently as a coping mechanism. Another house officer, with a family background of alcoholism, substantially increased his drinking during house jobs and progressed to intravenous heroin use. Some of these difficulties could have been detected by occupational health services. Many of our subjects would have been prime candidates for early intervention, when the prognosis is known to be better. Indeed, one anxious doctor who spent lonely evenings drinking was detected by an occupational health questionnaire. Another man, who worked in the pharmaceutical industry, was referred by the personnel department. These successful interventions should indicate the way forward. How sad it is that action (often major and formal) may take many years to be instigated, during which time the doctor addict incurs much morbidity.

How should colleagues respond?

The evidence from the case histories that were reviewed for this study is clear. To fail to act is to collude with the downfall of a colleague and may place patients at risk. Too often, action has been delayed because of uncertainty about what to do; the first answer is to refer for specialist intervention. Once in specialist treatment, the outlook is transformed. Quoted recovery rates vary greatly, but are commonly about 60% in different therapeutic regimes (Vogtsberger, 1984). The best outcome is reported by Shore (1987), who found that random urine monitoring was associated with stable improvement in 96% of a group of 25 addicted physicians.

Informal approaches may succeed in diverting the doctor into treatment. One GP was coerced into treatment by the combination of a drink-driving conviction and his senior partner's refusal to continue working with him. There are guidelines on intervening with dependent colleagues (Crosby & Bissell, 1989). If informal initiatives are ignored, further action is called for.

Helplines and services

Typically, colleagues hope for change for too long. They should undertake sympathetic and firm action, such as contacting the confidential National Counselling Service for Sick Doctors helpline

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(0171 580 3160), or the British Doctors' and Dentists' Group (via the Medical Council on Alcoholism, 0171 487 4445). Local Medical Committees run informal schemes to help sick general practitioners; in the case of hospital doctors, the local 'three wise men' could be contacted. Where other attempts have failed, or where there may be an imminent threat to patient safety, the GMC (0171 580 7642 ext. 3359) will provide advice (initially on an anonymous basis, if necessary) on further steps which may be taken.

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